

Division of Health Care Facilities		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/01/2021
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				
NAME OF PROVIDER OR SUPPLIER QUALITY CENTER FOR REHABILITATION AND		STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A complaint investigation #53466, #54016, #54093, #54334, #54348, and #54348 was completed on 7/1/2021 at Quality Center for Rehabilitation and Healing, LLC. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE*Adrienne Green*

STATE FORM

TITLE

Administrator

(X6) DATE

7/16/24

5899

5G8Q11

If continuation sheet 1 of 1